# Physician's/Practitioner's Certification Form

*(Family Medical Leave Act of 1993)*

*The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic Information' as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.*

1. Patient's Name: _____

2. Diagnosis: _____

3. Date condition commenced: _____

4. Probable duration of condition: _____

5. Treatment prescribed *(indicate dates and number of visits, general nature and duration of treatment, including referral to other providers of health services. Include schedule of visits or treatment if it is medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal schedule of hours per day or days per week.)*

6. Is inpatient hospitalization of the patient required? _____

7. If the patient is the employee, is the employee able to perform the functions of the employee's position? *(Answer after reviewing statement from employer of essential functions of employee's position, or if none provided, after discussing with employee.)*

8. If the answer to Question 7 is "No", explain why the employee is unable to perform the functions of the employee's position. Is the employee able to perform work of any kind? If yes, describe the type of work.

9. If the patient is not the employee, does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation? _____

10. After review of the employee's statement below, is the employee's presence necessary or would it be beneficial for the care of the patient? _____

11. Estimate the period of time the care is needed or the employee's presence would be beneficial:

_____

_____

_____

Physician/Practitioner Signature: _____ Date: _____

Printed/Typed Name of Physician/Practitioner: _____

Type of practice/field of specialization: _____

## TO BE COMPLETED BY THE EMPLOYEE:

1. I understand that obtaining the first medical opinion shall not be at the employer's expense. I understand that the employer may require a second opinion from a health care provider of the employer's choice and at the employer's expense. If the second opinion differs from the first, a final and binding third opinion may be sought from a mutually agreed upon health care provider (third opinion at the employer's expense).

2. I understand that failure to provide a complete and sufficient medical certification may result in a denial of my FMLA request.

3. I understand the Family Leave law makes it my responsibility to make reasonable efforts to schedule the leave so as not to unduly disrupt the employer's operations.

4. If Family Leave is to be taken intermittently due to your personal health condition, list the care you will be receiving, the schedule of such care, and the duration. If Family Leave is to be taken intermittently due to care for a seriously ill family member, list the care you will be providing, your schedule of such care, and the duration of your care:

   _____

   _____

   _____

   _____

Employee Signature: _____ Date: _____

**Return to:** **Judy Beutler, Deputy State Court Administrator**
**Administrative Office of the Courts/Probation**
**P. O. Box 98910**
**Lincoln, NE 68509-8910**
**(402) 471-2921**